State of Colorado
Flexible Spending Account (FSA)
Enrollment/Election Form

EMPLOYEE INFORMATION				
Your Name (Last, First, Middle)			Soc. Sec. No.	Dept./Agency Org. ID
Your Address	City	State	Zip	County
Home telephone	Work telephone			

FLEXIBLE SPENDING ACCOUNT ELECTIONS		
	Health Care FSA (247 PH) Maximum $6000 per year	**Dependent Care FSA** (248 PD) Maximum $5000 per year ($2500 if married and filing separately)
Annual Election	$	$
Monthly Payroll Deduction	$	$

Note: If new election, divide Annual Election by the number of months remaining in the Plan Year (January through December). If revised election, divide new Annual Election, reduced by payroll deductions to date, by the number of months remaining in the Plan Year.

CONSIDERATIONS

I understand that

- The following is intended to clarify commonly misunderstood provisions only. It is not a plan summary.
- My compensation will be reduced by the amount of the Monthly Payroll Deduction (salary reduction) each month through the end of the Plan Year (December 31).
- My Annual Elections are IRREVOCABLE and cannot be changed after the beginning of the Plan Year (or effective date) except as specifically provided in the State's Salary Reduction Plan Document and Section 125 of the Internal Revenue Code.
- I must report administrative errors (e.g., input errors) to my payroll or personnel administrator within ten (10) days following my first payroll deduction of the Plan Year.
- Claims for reimbursement will not be reimbursed until the first of the month following the first payroll deduction of the Plan Year.
- This Election will expire at the end of the Plan Year. I must make new FSA elections each year.
- Expenses incurred in any month in which a contribution is not made cannot be reimbursed.
- Reimbursement for health care expenses will be limited to the amount of my annual health care election in place on the date the expense is incurred.
- Insurance premiums are not eligible expenses and cannot be reimbursed.
- I may not deduct or claim tax credit for expenses reimbursed through my FSA on my tax return.
- My reimbursement request must be post-marked no later than April 15 following the end of the Plan Year. Any remaining balance will be forfeited.
- Coverage is effective the first of the month following date of hire (or initial eligibility) providing a properly completed enrollment/election form is submitted within 31 days of initial eligibility.

SIGNATURE

I authorize my employer to reduce my compensation by the amount of the specified Monthly Payroll Deduction for contribution to the Flexible Spending Account(s) indicated above.

Employee _____ Date _____

Please make and retain a copy of this form.
Submit the original to your agency payroll and personnel administrator.